STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
In CT 1-800-504-1102 (860) 241-8414 Fax (860) 525-6018
www.ct.gov/trb
October 2005

MEDICARE SUPPLEMENTAL HEALTH INSURANCE CHANGE FORM FOR JANUARY 1, 2006

Health Coverage Change Requirements

This is your annual opportunity to add or cancel coverage to your health insurance options through CTRB. If you are adding or dropping a coverage or canceling all of your coverage, complete the enclosed form and return it to the above address. Two change forms are enclosed with this notice. If a member and a spouse both have changes, you must each complete a separate form. If you are not adding or canceling coverage, please DO NOT submit an application. Once you enroll in a specific plan, no changes are allowed until January 2007.

Forms must be received in this office by **October 31, 2005**.

New Rates Effective January 1, 2006

Coverage Type	
Medicare Supplement with Prescriptions	$83.00
Medicare Supplement with Prescriptions & Dental	$120.50
Medicare Supplement with Prescriptions, Dental, Vision & Hearing	$124.50

Coverage Changes Effective January 1, 2006

The annual limitation for Dental coverage has increased to $2,000 and full coverage is available upon the effective date of coverage.

Notice of Creditable Coverage

You will be receiving a Notice of Creditable Coverage (NOCC) letter regarding your prescription plan with us under separate cover.

Medicare Part D

If you choose to enroll in Medicare Part D, your entire supplemental health coverage through the Teachers' Retirement Board will automatically be terminated.

PLEASE RETAIN THIS DOCUMENT

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phone 860-241-8414 fax 860-525-6018
Toll Free 1 800 504-1102
Website www.ct.gov/trb

HEALTH INSURANCE CHANGE FORM

This form is to be completed by members and spouses who are currently enrolled in a TRB Health Plan and are adding, dropping or terminating coverage.

- SUBMIT A COPY OF YOUR MEDICARE CARD EVEN IF YOU ARE CURRENTLY ENROLLED IN A STIRLING & STIRLING PLAN AND WISH ONLY TO CHANGE YOUR COVERAGE.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY OCTOBER 31, 2005.
- All changes will be effective JANUARY 1, 2006.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person per month	**Check one(x)**
Medicare Supplement with Prescriptions	$ 83.00	☐
Medicare Supplement with Prescriptions and Dental	$ 120.50	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$ 124.50	☐
Cancel all TRB coverage effective January 1, 2006		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number